		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020131

Facility Name: JACKSONVILLE CONVALESCENT CENTER

Address: 1517 WEST WALNUT (Number) JACKSONVILLE (City) 62650 (Zip Code)

County: MORGAN

Telephone Number: (217) 243-6451 **Fax #** (217) 243-8295

IDPA ID Number: 370983545001

Date of Initial License for Current Owners: AUGUST 1974

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** (217) 787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) JERRY W. JENNINGS
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENT # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	100,546	12,697	5,900	119,143		119,143		119,143			1
2	Food Purchase		118,991		118,991		118,991	(3,891)	115,100			2
3	Housekeeping	41,306	13,005		54,311		54,311		54,311			3
4	Laundry	19,016	11,897		30,913		30,913		30,913			4
5	Heat and Other Utilities			58,503	58,503		58,503		58,503			5
6	Maintenance	34,396	21,590	34,571	90,557		90,557	1,518	92,075			6
7	Other (specify):* Utility Worker	50,744			50,744		50,744		50,744			7
8	**TOTAL General Services**	246,008	178,180	98,974	523,162		523,162	(2,373)	520,789			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,116,929	183,828	164,443	1,465,200	(104,562)	1,360,638	(17,305)	1,343,333			10
10a	Therapy	38,134	550	229,889	268,573	(229,889)	38,684		38,684			10a
11	Activities	49,060	3,169		52,229		52,229		52,229			11
12	Social Services	18,127		4,882	23,009		23,009		23,009			12
13	Nurse Aide Training	1,765	53	3,368	5,186		5,186		5,186			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,224,015	187,600	414,582	1,826,197	(334,451)	1,491,746	(17,305)	1,474,441			16
	C. General Administration											
17	Administrative	58,825		10,754	69,579	2,066	71,645	40,212	111,857			17
18	Directors Fees											18
19	Professional Services			251,052	251,052		251,052	(241,620)	9,432			19
20	Dues, Fees, Subscriptions & Promotions			14,171	14,171		14,171	(6,085)	8,086			20
21	Clerical & General Office Expenses	54,815	15,543	5,445	75,803		75,803	30,416	106,219			21
22	Employee Benefits & Payroll Taxes			251,252	251,252		251,252	18,118	269,370			22
23	Inservice Training & Education			3,710	3,710		3,710	1,087	4,797			23
24	Travel and Seminar			5,466	5,466	(5,375)	91	553	644			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			114,721	114,721		114,721	254	114,975			26
27	Other (specify):*			62,349	62,349		62,349	(62,349)				27
28	**TOTAL General Administration**	113,640	15,543	718,920	848,103	(3,309)	844,794	(219,414)	625,380			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,583,663	381,323	1,232,476	3,197,462	(337,760)	2,859,702	(239,092)	2,620,610			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	61	Skilled (SNF)	61	22,265	1
2		Skilled Pediatric (SNF/PED)			2
3	27	Intermediate (ICF)	27	9,855	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,120	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,125	4,125	8
9	SNF/PED					9
10	ICF	16,206	9,081		25,287	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,206	9,081	4,125	29,412	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.57%

D. How many bed-hold days during this year were paid by Public Aid?
157 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/74

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 61 and days of care provided 4,125

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/03 Fiscal Year: 06/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER #0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			20,553	20,553		20,553	4,906	25,459			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,044	4,044		4,044	(4,044)				32
33	Real Estate Taxes			26,115	26,115		26,115		26,115			33
34	Rent-Facility & Grounds			132,000	132,000		132,000	(126,981)	5,019			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			182,712	182,712		182,712	(126,119)	56,593			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					337,760	337,760		337,760			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,180	48,180		48,180		48,180			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			48,180	48,180	337,760	385,940		385,940			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,583,663	381,323	1,463,368	3,428,354		3,428,354	(365,211)	3,063,143			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,585)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,469)	30		9
10	Interest and Other Investment Income	(1,709)	32		10
11	Discounts, Allowances, Rebates & Refunds	(538)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,210)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(355)	20		17
18	Fines and Penalties	(17,550)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,134)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,589)	27		24
25	Fund Raising, Advertising and Promotional	(5,926)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(33,955)	VAR.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (104,020)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(261,191)	VARIOUS	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (261,191)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (365,211)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	THERAPY	X		229,889	10a	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		2,740	10	42
43	Prescription Drugs	X		90,960	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule Supplies	X		472	10	45
46	Other-Attach Schedule IV's - Oxyg	X		13,699	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 337,760		47

STATE OF ILLINOIS
JACKSONVILLE CONVALESCENT CENTER
ID# 0020131
Report Period Beginning: 07/01/02
Ending: 06/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VENDING	$ (1,306)	2	1
2	EXPENSE REIMBURSEMENT	(22,649)	10	2
3	SETTLEMENTS	(10,000)	27	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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27				27
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(33,955)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,891)	0	0	0	0	0	0	0	0	0	0	(3,891)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,891)	0	0	0	0	0	0	0	0	0	0	(3,891)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(22,649)	0	0	0	0	0	0	0	0	0	0	(22,649)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(22,649)	0	0	0	0	0	0	0	0	0	0	(22,649)	16
	C. General Administration													
17	Administrative	0	249	0	0	0	0	0	0	0	0	0	249	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,134)	(242,296)	0	0	0	0	0	0	0	0	0	(243,430)	19
20	Fees, Subscriptions & Promotions	(6,281)	175	0	0	0	0	0	0	0	0	0	(6,106)	20
21	Clerical & General Office Expenses	(538)	14	0	0	0	0	0	0	0	0	0	(524)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(249)	0	0	0	0	0	0	0	0	0	(249)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(62,349)	0	0	0	0	0	0	0	0	0	0	(62,349)	27
28	**TOTAL General Administration**	(70,302)	(242,107)	0	0	0	0	0	0	0	0	0	(312,409)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(96,842)	(242,107)	0	0	0	0	0	0	0	0	0	(338,949)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(5,469)	8,782	0	0	0	0	0	0	0	0	0	3,313	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,709)	(2,335)	0	0	0	0	0	0	0	0	0	(4,044)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(132,000)	0	0	0	0	0	0	0	0	0	(132,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,178)	(125,553)	0	0	0	0	0	0	0	0	0	(132,731)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(104,020)	(367,660)	0	0	0	0	0	0	0	0	0	(471,680)	45

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
H. RAYMOND KLEIN, TRUSTEE	25%	D'ADRIAN CONVALESCENT CENTER	GODFREY	Nursing HomeMngrs	SPRINGFIELD	MANAGEMENT
SAM KLEIN	25%	HILLTOP NURSING HOME	CHARLESTON	J'ville Land Trust	SPRINGFIELD	LAND TRUST
DORYS BERG, TRUSTEE	50%	MEADOW MANOR	TAYLORVILLE			
		MENARD CONVALESCENT CENTER	PETERSBURG			
		SUNRISE MANOR OF VIRDEN	VIRDEN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 132,000	JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	$	$ (132,000)	1
2	V	30	DEPRECIATION		JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	8,782	8,782	2
3	V	20	TRUST FEES		JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	175	175	3
4	V	21	OFFICE EXPENSE		JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	14	14	4
5	V	32	INTEREST		JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	(2,335)	(2,335)	5
6	V								6
7	V	19	MANAGEMENT FEES	249,633	NURSING HOME MANAGERS, INC.	50.00%		(249,633)	7
8	V	VAR	SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS, INC.	50.00%	106,469	106,469	8
9	V	19	ACCOUNTING		NURSING HOME MANAGERS, INC. DIRECT ALLOCATION	50.00%	7,337	7,337	9
10	V	24	TRAVEL	249	TO TRANSFER 31% OF HOME OFFICE TRAVEL	50.00%		(249)	10
11	V	17	ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE - PER DESK REVIEW	50.00%	249	249	11
12	V								12
13	V								13
14	Total			$ 381,882			$ 120,691	$ * (261,191)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CEN # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	H. RAYMOND KLEIN	OWNER	MANAGEMENT	25.00					$ 2,406	17 - 7	1
2											2
3											3
4											4
5		H. RAYMOND KLEIN WAS PAID BY NURSING HOME MANAGERS, INC., A RELATED									5
6		ORGANIZATION. TOTAL COMPENSATION OF $10,010 WAS ALLOCATED AMONG									6
7		THE SIX RELATED NURSING HOMES BASED UPON 10 HOURS PER WEEK FOR									7
8		H. RAYMOND KLEIN.									8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,406		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS, INC.
Street Address: 2653 WEST LAWRENCE - SUITE B
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE ATTACHED SCHEDULES				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENT # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	J'VILLE LAND TRUST	X		WORKING CAPITAL		12/06/02	50,000	74,000		5.0000	1,948	6
7	BANK OF SPRINGFIELD		X	WORKING CAPITAL	INTEREST	01/30/03	100,000			4.2500	2,096	7
8												8
9	TOTAL Facility Related						$ 150,000	$ 74,000			$ 4,044	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 150,000	$ 74,000			$ 4,044	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	$	39,041	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	26,027	2
3. Under or (over) accrual (line 2 minus line 1).	$	(13,014)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	39,129	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	26,115	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	31,046	8
1999	25,115	9
2000	25,319	10
2001	26,027	11
2002	26,086	12

LINE 4: 2002 TAX BILL	$26,086	
6/12 OF $26,086	13,043	
2003 ACCRUAL	$39,129	

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME JACKSONVILLE CONVALESCENT CENTER COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0020131

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE (217) 787-8530 FAX #: (217) 787-9840

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-18-301-002	JACKSONVILLE CONV. CENTER	$ 26,085.68	$ 26,085.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 26,085.68	$ 26,085.68

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,061 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1974	$ 35,003	1
2	TITLE WORK		1989	426	2
3	TOTALS			$ 35,429	3

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1974	1974	$ 541,766	$ 6,712	30	$	$ (6,712)	$ 541,766	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1975	3,850		5			3,850	9
10	AIR CONDITIONING / HEATING			1974	14,470		8			14,470	10
11	MOTORS			1980	533		5			533	11
12	BIDS			1981	739	22	30	25	3	558	12
13	FURNACE			1981	678		8			678	13
14	FAN			1981	972		15			972	14
15	USED AIR CONDITIONER			1982	2,000		8			2,000	15
16	VACUUM REPAIR - PER 1982 AUDIT			1982	1,031		10			1,031	16
17	FLOORING			1983	1,229		10			1,229	17
18	WATER HEATER			1983	1,498		8			1,498	18
19	WATER HEATER			1983	1,575		8			1,575	19
20	CEILING AND DOORS			1984	2,041		15			2,041	20
21	ASPHALT			1984	13,350		15			13,350	21
22	AIR CONDITIONER			1987	1,155		8			1,155	22
23	SIDEWALKS			1987	6,700	213	20	335	122	5,193	23
24	ROOF			1988	21,783	692	20	1,090	398	15,791	24
25	LIGHT DIFFUSER			1990	1,054	34	10		(34)	1,054	25
26	FLOORING			1990	1,030	33	15	69	36	861	26
27	WATER HEATER			1992	1,450	46	15	97	51	1,114	27
28	AIR CONDITIONER			1992	1,025		10	50	50	1,025	28
29	REWIRE FIXTURES			1992	1,110	35	10	55	20	1,110	29
30	COMPRESSOR			1993	1,479	38	10	148	110	1,405	30
31	DOOR STOPS			1993	2,168	56	15	145	89	1,370	31
32	ROOF			1993	34,178	876	20	1,709	833	16,234	32
33	FIRE DOORS			1996	1,011	26	15	67	41	503	33
34	WATER HEATER			1997	3,915	100	15	261	161	1,621	34
35	AIR CONDITIONER			1997	5,982	153	10	598	445	3,588	35
36	SWAMP COOLER			1998	1,125	29	8	141	112	728	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	1998	$ 1,950	$ 50	15	$ 130	$ 80	$ 617	37
38	DOOR ENTRANCE	1999	2,672	69	15	178	109	668	38
39	SHUTTERS	1999	912	23	15	61	38	223	39
40	DOOR ENTRANCE	2000	4,507	116	15	300	184	950	40
41	DUCT SMOKE DETECTORS	2000	2,295	59	20	115	56	335	41
42	DOOR	2000	2,280	59	15	152	93	418	42
43	ROOFTOP AIR CONDITIONER	2001	7,619	195	10	762	567	1,397	43
44	COMBUSTION AIR DUCT	2002	710	18	15	47	29	71	44
45	SMOKE DETECTORS	2002	2,511	64	15	167	103	209	45
46	GARAGE	2002	11,636	298	15	776	478	905	46
47	SMOKE DETECTORS	2002	809	21	15	54	33	63	47
48	FIRE DAMPERS	2002	1,166	30	15	78	48	91	48
49	ROOFTOP AIR CONDITIONER & HEATING (2)	2002	9,766	120	8	635	515	635	49
50	GARAGE INSULATION	2003	1,652	12	15	37	25	37	50
51	ROOFTOP AIR CONDITIONER & HEATING	2003	5,300	17	8	110	93	110	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 726,682	$ 10,216		$ 8,392	$ (1,824)	$ 645,032	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 157,333	$ 14,913	$ 13,903	$ (1,010)	Various	$ 83,952	71
72	Current Year Purchases	20,751	4,206	1,571	(2,635)	Various	1,571	72
73	Fully Depreciated Assets	127,121					127,121	73
74	Assets No Longer in Service	(77,603)					(77,603)	74
75	TOTALS	$ 227,602	$ 19,119	$ 15,474	$ (3,645)		$ 135,041	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 989,713	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 29,335	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 23,866	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,469)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 780,073	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: JACKSONVILLE CONVALESCENT CENTER LAND TRUST
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1974	88	08/01/74	$ 132,000			3
4	Additions							4
5								5
6								6
7	TOTAL		88		$ 132,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 07/01/02
Ending 06/30/03

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	06/30/2004	$ 132,000
13.	06/30/2005	$ 132,000
14.	06/30/2006	$ 132,000

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ Description: INCLUDED IN THE ABOVE AMOUNT
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 84

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 321	$	$ 321
2	Books and Supplies			53		53
3	Classroom Wages	(a)		1,147		1,147
4	Clinical Wages	(b)		618		618
5	In-House Trainer Wages	(c)				
6	Transportation			126		126
7	Contractual Payments			2,771		2,771
8	Nurse Aide Competency Tests			150		150
9	TOTALS		$	$ 5,186	$	$ 5,186
10	SUM OF line 9, col. 1 and 2	(e)	$ 5,186			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 8	hrs	$	1,954	$	107,404	$	1,954	$ 107,404	1
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		126		7,278		126	7,278	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 8	hrs		2,196		115,207		2,196	115,207	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 8	# of prescrpts					90,960		90,960	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): Oxy,Lab,IV,Supplies	39 - 8						16,911		16,911	13
14	TOTAL			$	4,275	$	229,889	$ 107,871	4,275	$ 337,760	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,174	$ 125,743	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	416,852	416,852	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,595	28,595	6
7	Other Prepaid Expenses	67,076	67,076	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 517,697	$ 638,266	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		35,429	13
14	Buildings, at Historical Cost		658,844	14
15	Leasehold Improvements, at Historical Cost	66,807	66,807	15
16	Equipment, at Historical Cost	211,100	303,264	16
17	Accumulated Depreciation (book methods)	(167,410)	(864,835)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 110,497	$ 199,509	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 628,194	$ 837,775	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 126,585	$ 126,585	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	74,000		29
30	Accrued Salaries Payable	73,215	73,215	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,036	14,036	31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,129	39,129	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 326,965	$ 252,965	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 326,965	$ 252,965	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 301,229	$ 584,810	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 628,194	$ 837,775	48

***(See instructions.)**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 673,976	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 673,976	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(199,530)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **LAND TRUST INCOME**	125,364	15
16	Other (describe) **LAND TRUST DISTR. TO OWNERS**	(15,000)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (89,166)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 584,810	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,359,017	1
2	Discounts and Allowances for all Levels	(238,610)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,120,407	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	77,818	6
7	Oxygen	918	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 78,736	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,585	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,585	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,603	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,603	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING $1,306 ADMIT FEE $450	1,756	28
28a	EXPENSE REIMB $22,649 W/A $88	22,737	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 24,493	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,228,824	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	523,162	31
32	Health Care	1,826,197	32
33	General Administration	848,103	33
	B. Capital Expense		
34	Ownership	182,712	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	48,180	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,428,354	40
41	**Income before Income Taxes (line 30 minus line 40)****	(199,530)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (199,530)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,040	2,080	$ 47,140	$ 22.66	1
2	Assistant Director of Nursing	248	257	4,573	17.79	2
3	Registered Nurses	6,934	7,194	161,642	22.47	3
4	Licensed Practical Nurses	20,279	20,889	328,444	15.72	4
5	Nurse Aides & Orderlies	58,807	60,069	575,130	9.57	5
6	Nurse Aide Trainees	343	343	1,765	5.15	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,174	3,429	38,134	11.12	8
9	Activity Director	1,813	1,924	17,138	8.91	9
10	Activity Assistants	5,485	5,598	31,922	5.70	10
11	Social Service Workers	2,037	2,213	18,127	8.19	11
12	Dietician					12
13	Food Service Supervisor	2,306	2,407	29,443	12.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,755	10,245	71,103	6.94	15
16	Dishwashers					16
17	Maintenance Workers	3,645	3,926	34,396	8.76	17
18	Housekeepers	5,882	6,255	41,306	6.60	18
19	Laundry	2,717	2,859	19,016	6.65	19
20	Administrator	1,960	2,400	54,848	22.85	20
21	Assistant Administrator	280	320	3,977	12.43	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,077	5,387	54,815	10.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	9,433	9,523	50,744	5.33	33
34	TOTAL (lines 1 - 33)	142,215	147,318	$ 1,583,663 *	$ 10.75	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	200	$ 5,900	1 - 3	35
36	Medical Director	120	12,000	9 - 3	36
37	Medical Records Consultant	16	502	10 - 3	37
38	Nurse Consultant	838	33,898	10 - 3	38
39	Pharmacist Consultant	96	1,350	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	84	4,882	12 - 3	45
46	Other(specify)				46
47	MEDICARE CONSULTANT	144	18,021	10 - 3	47
48	ADMINISTRATIVE CONSULTANT	344	10,754	17 - 3	48
49	TOTAL (lines 35 - 48)	1,842	$ 87,307		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	86	$ 3,308	10 - 3	50
51	Licensed Practical Nurses	2,666	81,375	10 - 3	51
52	Nurse Aides	1,288	25,989	10 - 3	52
53	TOTAL (lines 50 - 52)	4,039	$ 110,672		53

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANNA NEWINGHAM	ADMINISTRATOR	0	$ 10,227
LUDENE BLACK	ADMINISTRATOR	0	44,621
DANA SEYMOUR	ASST. ADMIN.	0	3,977
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,825

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 10,754
TOTAL (agree to Schedule V, line 17, col. 3)	$ 10,754
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NURSING HOME MANAGERS	MANAGEMENT	$ 249,633
C S C	CORP. REPRESENTATION	285
Feldman,Wasser,Draper&Benson	LEGAL	1,134
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 251,052

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,431
Unemployment Compensation Insurance	27,414
FICA Taxes	117,650
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
CAFETERIA - 125 PLAN	31,501
EMPLOYEE LIFE INSURANCE	3,193
HBV VACCINE	1,635
GIFT CERTIFICATES	1,395
CHRISTMAS PARTY	870
EMPLOYEE APPRECIATION	163
NURSING HOME MANAGERS ALLOCATION	18,118
TOTAL (agree to Schedule V, line 22, col.8)	$ 269,370

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
HBV VACCINE	22	$ 1,635
GIFT CERTIFICATES	22	1,395
CHRISTMAS PARTY	22	870
EMPLOYEE APPRECIATION	22	163
TOTAL		$ 4,063

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	6,003
Health Care Worker Background Check	1,587
(Indicate # of checks performed 122)	
SEE ATTACHED SCHEDULE	6,381
J'VILLE LAND TRUST - TRUST FEES	175
NURSING HOME MANAGERS ALLOC.	21
Less: Non-allowable dues & fees	(355)
Less: Public Relations Expense	(5,926)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,086

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MISCELLANEOUS MILEAGE REIMB.	91
NURSING HOME MANAGES ALLOC.	553
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 644

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINT	7/90 - 6/91	$ 1,384	3 YRS	$	$	$	$	$	$	$	$	$
2	INTERIOR PAINT	7/92 - 6/93	1,970	3 YRS									
3	WALLPAPER & PAINT	7/93 - 6/94	6,214	3 YRS									
4	WALLPAPER & PAINT	7/94 - 6/95	3,051	3 YRS									
5	WALLPAPER & PAINT	7/96 - 6/97	4,944	3 YRS	824								
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 17,563		$ 824	$	$	$	$	$	$	$	$

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/02 Ending: 06/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **9 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,157** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **48,180**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **2,585**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

PAGE 2 - SCHEDULE III - K

OF BEDS CERTIFIED MEDICARE

7/1/02 - 12/31/02	27 BEDS
1/1/03 - 6/30/03	61 BEDS

PAGE 3 & 4 - SCHEDULE V

LINE 27 - GENERAL ADMINISTRATION - OTHER

SALES TAX	$	5,210
BAD DEBTS		29,589
SETTLEMENTS		10,000
FINES & PENALTIES		17,550
TOTAL LINE 27 - COLUMN 3	$	62,349

LINE 23 - INSERVICE TRAINING & EDUCATION - DETAIL

HOME OFFICE INSERVICES - VARIOUS	$	330
DENTAL INSERVICE		250
SOCIAL SERVICE INSERVICE		357
MDS SEMINARS & COURSE		280
HOUSEKEEPING & LAUNDRY WORKSHOP		100
ADMINISTRATOR TEST & CLASS		447
ACTIVITY COURSE & TRAVEL		933
PHYSICAL THERAPY AIDE TRAINING		238
REHAB & RESTORATIVE NURSE COURSE		395
FOOD SERVICE SANITATION COURSE		50
LIFE SAFETY TRAINING		330
NURSING HOME MANAGERS ALLOCATION		1,087
TOTAL LINE 23 - COLUMN 8	$	4,797

PAGE 3 & 4 - SCHEDULE V

DETAIL COLUMN 5 - RECLASSIFICATIONS

			LINE #
RECLASS TO:			
NURSE CONSULTANT TRAVEL:	$	3,309	10
ADMINISTRATIVE CONSULTANT TRAVEL		2,066	17
RECLASS FROM: TRAVEL	$	(5,375)	24
RECLASS FROM:			
MEDICARE SUPPLIES	$	(472)	10
MEDICARE X-RAYS		(114)	10
MEDICARE DRUGS		(90,960)	10
MEDICARE LABORATORY FEES		(2,626)	10
MEDICARE I.V. THERAPY		(2,131)	10
OXYGEN		(11,568)	10
PHYSICAL THERAPY		(115,207)	10A
SPEECH THERAPY		(7,278)	10A
OCCUPATIONAL THERAPY		(107,404)	10A
RECLASS TO: ANCILLARY SERVICES	$	337,760	39

PAGE 9 - SCHEDULE IX - LINE 6

INTEREST PAID TO JACKSONVILLE LAND TRUST IS OFFSET ON PAGE 6 SCHEDULE VII - SECTION B - LINE 5 - RELATED ORGANIZATION TRANSACTI AS PART OF JACKSONVILLE LAND TRUST INTEREST INCOME. THEREFORE THIS INTEREST IN NOT ADJUSTED ON PAGE 5 LINE 14.

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PAGE 13 - SCHEDULE XI - SECTION E

RECONCILIATION OF DEPRECIATION	
LINE 83 - STRAIGHT LINE DEPRECIATION	$ 23,866
NURSING HOME MANAGERS ALLOCATION	1,593
SCHEDULE V - LINE 30 - COLUMN 8	$ 25,459

PAGE 15 - SCHEDULE XII

AIDES TRAINED AT: SUNRISE MANOR OF VIRDEN, INC.
333 S. WRIGHTSMAN
VIRDEN, IL 62690

COST PER AIDE TRAINED: $923.67

PAGE 23 - SCHEDULE XX

QUESTION #12
SALARY COSTS ARE ALLOCATED TO DEPARTMENT WORKED BASED UPON TIME CARDS.

PAGE 19 - SCHEDULE XVII

RECONCILIATION OF INCOME	
NET INCOME - LINE 43	$ (199,530)
* MANAGEMENT FEE 6/30/02	(39,140)
* MANAGEMENT FEE 6/30/03	16,824
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	(2,603)
TAXABLE INCOME	$ (224,449)

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR T
PURPOSES INCLUDED HERE FOR CONSISTENCY WITH PRIOR
COST REPORTS AND TO CONFORM WITH ACCRUAL ACCOUNT
METHODS.

PAGE 21 - SCHEDULE XIX - SECTION F

DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS	
PUBLIC RELATIONS	$ 5,926
CHAMBER OF COMMERCE DUES	180
FRANCHISE FEES	100
ADMINISTRATOR LICENSE	175
	$ 6,381

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SCHEDULE VII - PAGE 6, LINE 8

CENTRAL OFFICE COST ALLOCATION
JACKSONVILLE
2002

	JULY 02	AUG	SEPT	OCT	NOV	DEC	JAN 03	FEB	MARCH	APRIL	MAY	JUNE	2002 TOTAL	LINE #
SALARIES-ADMIN	$2,787	$2,904	$2,881	$2,833	$2,908	$3,138	$3,344	$3,358	$3,404	$3,303	$3,381	$3,318	$37,557	17
SALARIES-CLERIC	1,871	2,100	2,084	2,049	2,104	2,269	2,439	2,449	2,482	2,409	2,465	2,419	27,140	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	588	216	214	211	216	233	610	612	621	602	616	605	5,344	10
ACCOUNTING	71	78	77	76	78	84	224	225	228	221	226	222	1,810	19
WORK COMP INS	16	28	28	28	28	31	41	41	42	41	42	41	407	22
SUPPLIES	98	175	174	171	175	189	179	179	182	176	180	177	2,056	21
TELEPHONE	85	116	115	113	116	125	179	179	182	176	181	177	1,744	21
EMPL BENEFITS	802	1,090	1,081	1,063	1,092	1,178	988	992	1,005	975	998	980	12,244	22
PAYROLL TAXES	369	363	360	354	363	392	543	545	553	537	549	539	5,467	22
TRAVEL	58	46	45	45	46	50	85	86	87	84	86	85	802	24
IN SERVICE	34	113	112	110	113	122	81	81	82	80	82	80	1,087	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	19	21	21	20	21	23	65	66	66	65	66	65	517	6
OWNERS COMP	171	187	185	182	187	202	215	216	219	212	217	213	2,406	17
INS-PROP,LIAB,WC	41	10	10	10	10	11	27	27	28	27	27	27	254	26
DEPRECIATION	139	92	92	90	93	100	164	165	167	162	166	163	1,593	30
RENT	360	384	381	374	384	415	453	454	461	447	458	449	5,019	34
MAINTENANCE	82	85	84	83	85	92	82	82	83	81	82	81	1,001	6
FEES & PUBLICAT	0	0	0	0	0	0	0	0	0	0	0	0	0	20
ADVERTISING	0	4	4	4	4	5	0	0	0	0	0	0	21	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$7,591	$8,012	$7,947	$7,815	$8,024	$8,656	$9,717	$9,757	$9,891	$9,597	$9,823	$9,640	$106,469	
FIXED ASSETS													106,469	
EQUIP - PRIOR	11,823	12,620	12,518	12,310	12,639	13,635	16,257	16,322	10,959	10,633	10,883	10,681	12,607	
EQUIP - CURR	1,092	1,166	1,156	1,137	1,167	1,259	0	0	4,707	4,567	4,675	4,588	2,126	
EQUIP - FULLY DEP	3,948	4,214	4,180	4,110	4,220	4,553	4,969	4,989	5,058	4,908	5,023	4,930	4,592	
BLDG - PRIOR	1,391	1,484	1,472	1,448	1,486	1,604	1,750	1,757	1,782	1,729	1,769	1,736	1,617	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

JACKSONVILLE CONVALESCENT CENTER #0020131 PAGE 27 07/01/02 TO 06/30/03
MONTHLY CENTRAL OFFICE
COST ALLOCATIONS

NURSING HOME MANAGERS
COST ALLOCATION
JULY 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	14.75%	14.18%	20.68%	15.42%	14.22%	20.76%	100.00%
SALARIES-ADMIN	$1,988	$1,911	$2,787	$2,078	$1,917	$2,798	$13,480
SALARIES-CLERIC	1,334	1,283	1,871	1,395	1,287	1,878	9,048
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	420	403	588	438	405	590	2,844
ACCOUNTING	50	48	71	53	49	71	342
WORK COMP INS	12	11	16	12	11	17	80
SUPPLIES	70	67	98	73	68	99	475
TELEPHONE	61	58	85	63	59	85	412
EMPL BENEFITS	572	550	802	598	552	805	3,881
PAYROLL TAXES	263	253	369	275	253	370	1,782
TRAVEL	41	40	58	43	40	58	280
IN SERVICE	24	23	34	25	23	34	164
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	13	13	19	14	13	19	91
OWNERS COMP	122	117	171	127	117	171	825
INS-PROP,LIAB,WC	30	28	41	31	28	42	200
DEPRECIATION	99	95	139	104	96	140	673
RENT	257	247	360	268	247	361	1,739
MAINTENANCE	58	56	82	61	56	82	395
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,415	$5,205	$7,591	$5,659	$5,222	$7,620	$36,712
FIXED ASSETS							
EQUIP - PRIOR	8,433	8,108	11,823	8,815	8,133	11,868	57,179
EQUIP - CURR	779	749	1,092	814	751	1,096	5,281
EQUIP - FULLY DEP	2,816	2,707	3,948	2,943	2,715	3,963	19,092
BLDG - PRIOR	992	954	1,391	1,037	957	1,396	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	14.05%	13.99%	22.07%	16.09%	12.99%	20.82%	100.00%
SALARIES-ADMIN	$1,849	$1,840	$2,904	$2,117	$1,709	$2,739	$13,158
SALARIES-CLERIC	1,337	1,331	2,100	1,531	1,236	1,981	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	137	137	216	157	127	204	978
ACCOUNTING	49	49	78	57	46	73	352
WORK COMP INS	18	18	28	21	17	27	128
SUPPLIES	111	111	175	128	103	165	794
TELEPHONE	74	73	116	85	68	109	525
EMPL BENEFITS	694	691	1,090	794	641	1,028	4,938
PAYROLL TAXES	231	230	363	264	213	342	1,644
TRAVEL	29	29	46	33	27	43	208
IN SERVICE	72	71	113	82	66	106	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	13	13	21	15	12	20	95
OWNERS COMP	119	118	187	136	110	176	847
INS-PROP,LIAB,WC	6	6	10	7	6	9	45
DEPRECIATION	59	59	92	67	54	87	419
RENT	244	243	384	280	226	362	1,739
MAINTENANCE	54	54	85	62	50	80	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	3	3	4	3	2	4	19
	0	0	0	0	0	0	0
TOTAL	$5,100	$5,077	$8,012	$5,839	$4,714	$7,558	$36,300
FIXED ASSETS							
EQUIP - PRIOR	8,033	7,998	12,620	9,198	7,426	11,905	57,179
EQUIP - CURR	742	739	1,166	850	686	1,100	5,281
EQUIP - FULLY DEP	2,682	2,670	4,214	3,071	2,479	3,975	19,092
BLDG - PRIOR	945	941	1,484	1,082	873	1,400	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	13.70%	14.53%	21.89%	16.16%	13.00%	20.71%	100.00%
SALARIES-ADMIN	$1,803	$1,912	$2,881	$2,127	$1,710	$2,725	$13,158
SALARIES-CLERIC	1,304	1,383	2,084	1,538	1,237	1,971	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	134	142	214	158	127	203	978
ACCOUNTING	48	51	77	57	46	73	352
WORK COMP INS	18	19	28	21	17	27	128
SUPPLIES	109	115	174	128	103	164	794
TELEPHONE	72	76	115	85	68	109	525
EMPL BENEFITS	677	718	1,081	798	642	1,023	4,938
PAYROLL TAXES	225	239	360	266	214	340	1,644
TRAVEL	28	30	45	34	27	43	208
IN SERVICE	70	74	112	82	66	106	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	13	14	21	15	12	20	95
OWNERS COMP	116	123	185	137	110	175	847
INS-PROP,LIAB,WC	6	7	10	7	6	9	45
DEPRECIATION	57	61	92	68	54	87	419
RENT	238	253	381	281	226	360	1,739
MAINTENANCE	53	56	84	62	50	80	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	3	3	4	3	2	4	19
	0	0	0	0	0	0	0
TOTAL	$4,975	$5,275	$7,947	$5,868	$4,718	$7,517	$36,300
FIXED ASSETS							
EQUIP - PRIOR	7,836	8,309	12,518	9,243	7,432	11,841	57,179
EQUIP - CURR	724	767	1,156	854	686	1,094	5,281
EQUIP - FULLY DEP	2,617	2,774	4,180	3,086	2,482	3,954	19,092
BLDG - PRIOR	922	977	1,472	1,087	874	1,393	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	12.95%	15.00%	21.53%	16.58%	13.53%	20.41%	100.00%
SALARIES-ADMIN	$1,704	$1,973	$2,833	$2,182	$1,780	$2,685	$13,158
SALARIES-CLERIC	1,233	1,427	2,049	1,578	1,288	1,942	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	127	147	211	162	132	200	978
ACCOUNTING	46	53	76	58	48	72	352
WORK COMP INS	17	19	28	21	17	26	128
SUPPLIES	103	119	171	132	107	162	794
TELEPHONE	68	79	113	87	71	107	525
EMPL BENEFITS	640	741	1,063	819	668	1,008	4,938
PAYROLL TAXES	213	247	354	273	222	335	1,644
TRAVEL	27	31	45	34	28	42	208
IN SERVICE	66	76	110	85	69	104	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	12	14	20	16	13	19	95
OWNERS COMP	110	127	182	140	115	173	847
INS-PROP,LIAB,WC	6	7	10	7	6	9	45
DEPRECIATION	54	63	90	69	57	86	419
RENT	225	261	374	288	235	355	1,739
MAINTENANCE	50	58	83	64	52	78	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	2	3	4	3	3	4	19
	0	0	0	0	0	0	0
TOTAL	$4,702	$5,444	$7,815	$6,019	$4,912	$7,408	$36,300
FIXED ASSETS							
EQUIP - PRIOR	7,407	8,575	12,310	9,481	7,737	11,669	57,179
EQUIP - CURR	684	792	1,137	876	715	1,078	5,281
EQUIP - FULLY DEP	2,473	2,863	4,110	3,166	2,583	3,896	19,092
BLDG - PRIOR	871	1,008	1,448	1,115	910	1,372	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	12.31%	15.51%	22.10%	16.54%	13.40%	20.14%	100.00%
SALARIES-ADMIN	$1,619	$2,041	$2,908	$2,176	$1,763	$2,650	$13,158
SALARIES-CLERIC	1,171	1,476	2,104	1,574	1,275	1,917	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	120	152	216	162	131	197	978
ACCOUNTING	43	55	78	58	47	71	352
WORK COMP INS	16	20	28	21	17	26	128
SUPPLIES	98	123	175	131	106	160	794
TELEPHONE	65	82	116	87	70	106	525
EMPL BENEFITS	608	766	1,092	817	662	995	4,938
PAYROLL TAXES	202	255	363	272	220	331	1,644
TRAVEL	26	32	46	34	28	42	208
IN SERVICE	63	79	113	84	68	103	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	12	15	21	16	13	19	95
OWNERS COMP	104	131	187	140	113	171	847
INS-PROP,LIAB,WC	6	7	10	7	6	9	45
DEPRECIATION	52	65	93	69	56	84	419
RENT	214	270	384	288	233	350	1,739
MAINTENANCE	47	60	85	64	52	77	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	2	3	4	3	3	4	19
	0	0	0	0	0	0	0
TOTAL	$4,468	$5,632	$8,024	$6,003	$4,864	$7,311	$36,300
FIXED ASSETS							
EQUIP - PRIOR	7,037	8,871	12,639	9,455	7,662	11,515	57,179
EQUIP - CURR	650	819	1,167	873	708	1,064	5,281
EQUIP - FULLY DEP	2,350	2,962	4,220	3,157	2,558	3,845	19,092
BLDG - PRIOR	828	1,043	1,486	1,112	901	1,354	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	4.42%	17.00%	23.85%	17.58%	14.54%	22.61%	100.00%
SALARIES-ADMIN	$582	$2,237	$3,138	$2,313	$1,913	$2,975	$13,158
SALARIES-CLERIC	421	1,618	2,269	1,673	1,384	2,151	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	43	166	233	172	142	221	978
ACCOUNTING	16	60	84	62	51	80	352
WORK COMP INS	6	22	31	23	19	29	128
SUPPLIES	35	135	189	140	115	179	794
TELEPHONE	23	89	125	92	76	119	525
EMPL BENEFITS	218	840	1,178	868	718	1,116	4,938
PAYROLL TAXES	73	279	392	289	239	372	1,644
TRAVEL	9	35	50	37	30	47	208
IN SERVICE	23	87	122	90	74	115	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	4	16	23	17	14	21	95
OWNERS COMP	37	144	202	149	123	191	847
INS-PROP,LIAB,WC	2	8	11	8	7	10	45
DEPRECIATION	19	71	100	74	61	95	419
RENT	77	296	415	306	253	393	1,739
MAINTENANCE	17	65	92	68	56	87	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	1	3	5	3	3	4	19
	0	0	0	0	0	0	0
TOTAL	$1,606	$6,171	$8,656	$6,382	$5,278	$8,206	$36,300
FIXED ASSETS							
EQUIP - PRIOR	2,530	9,721	13,635	10,053	8,314	12,926	57,179
EQUIP - CURR	234	898	1,259	929	768	1,194	5,281
EQUIP - FULLY DEP	845	3,246	4,553	3,357	2,776	4,316	19,092
BLDG - PRIOR	298	1,143	1,604	1,182	978	1,520	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.14%	26.03%	18.33%	14.45%	23.05%	100.00%
SALARIES-ADMIN	$0	$2,331	$3,344	$2,356	$1,857	$2,961	$12,848
SALARIES-CLERIC	0	1,700	2,439	1,718	1,354	2,160	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	425	610	429	339	540	$2,343
ACCOUNTING	0	156	224	158	124	198	$861
WORK COMP INS	0	29	41	29	23	36	$158
SUPPLIES	0	124	179	126	99	158	$686
TELEPHONE	0	124	179	126	99	158	$686
EMPL BENEFITS	0	688	988	696	548	875	$3,795
PAYROLL TAXES	0	379	543	383	302	481	$2,087
TRAVEL	0	59	85	60	47	76	$328
IN SERVICE	0	56	81	57	45	71	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	46	65	46	36	58	$251
OWNERS COMP	0	150	215	151	119	190	$825
INS-PROP,LIAB,WC	0	19	27	19	15	24	$104
DEPRECIATION	0	114	164	116	91	145	$631
RENT	0	315	453	319	251	401	$1,739
MAINTENANCE	0	57	82	57	45	72	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,772	$9,717	$6,845	$5,395	$8,605	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	11,330	16,257	11,451	9,026	14,396	62,460
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,463	4,969	3,500	2,759	4,400	19,092
BLDG - PRIOR	0	1,220	1,750	1,233	972	1,550	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.59%	26.13%	18.79%	13.43%	23.05%	100.00%
SALARIES-ADMIN	$0	$2,389	$3,358	$2,414	$1,725	$2,962	$12,848
SALARIES-CLERIC	0	1,742	2,449	1,761	1,258	2,160	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	436	612	440	315	540	$2,343
ACCOUNTING	0	160	225	162	116	198	$861
WORK COMP INS	0	29	41	30	21	36	$158
SUPPLIES	0	128	179	129	92	158	$686
TELEPHONE	0	128	179	129	92	158	$686
EMPL BENEFITS	0	706	992	713	510	875	$3,795
PAYROLL TAXES	0	388	545	392	280	481	$2,087
TRAVEL	0	61	86	62	44	76	$328
IN SERVICE	0	58	81	58	42	71	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	47	66	47	34	58	$251
OWNERS COMP	0	153	216	155	111	190	$825
INS-PROP,LIAB,WC	0	19	27	20	14	24	$104
DEPRECIATION	0	117	165	118	85	145	$631
RENT	0	323	454	327	234	401	$1,739
MAINTENANCE	0	58	82	59	42	72	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,942	$9,757	$7,015	$5,014	$8,607	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	11,614	16,322	11,736	8,388	14,400	62,460
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,550	4,989	3,587	2,564	4,402	19,092
BLDG - PRIOR	0	1,250	1,757	1,264	903	1,550	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.42%	26.49%	19.41%	13.06%	22.62%	100.00%
SALARIES-ADMIN	$0	$2,367	$3,404	$2,494	$1,677	$2,906	$12,848
SALARIES-CLERIC	0	1,726	2,482	1,819	1,223	2,119	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	432	621	455	306	530	$2,343
ACCOUNTING	0	159	228	167	112	195	$861
WORK COMP INS	0	29	42	31	21	36	$158
SUPPLIES	0	126	182	133	90	155	$686
TELEPHONE	0	126	182	133	90	155	$686
EMPL BENEFITS	0	699	1,005	737	495	858	$3,795
PAYROLL TAXES	0	385	553	405	273	472	$2,087
TRAVEL	0	60	87	64	43	74	$328
IN SERVICE	0	57	82	60	40	70	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	46	66	49	33	57	$251
OWNERS COMP	0	152	219	160	108	187	$825
INS-PROP,LIAB,WC	0	19	28	20	14	24	$104
DEPRECIATION	0	116	167	122	82	143	$631
RENT	0	320	461	338	227	393	$1,739
MAINTENANCE	0	58	83	61	41	71	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,877	$9,891	$7,248	$4,874	$8,444	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,620	10,959	8,030	5,400	9,356	41,365
EQUIP - CURR	0	3,273	4,707	3,449	2,320	4,019	17,768
EQUIP - FULLY DEP	0	3,517	5,058	3,706	2,493	4,318	19,092
BLDG - PRIOR	0	1,239	1,782	1,306	878	1,521	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.58%	25.71%	19.78%	13.43%	22.50%	100.00%
SALARIES-ADMIN	$0	$2,387	$3,303	$2,542	$1,725	$2,891	$12,848
SALARIES-CLERIC	0	1,741	2,409	1,854	1,258	2,108	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	435	602	463	315	527	$2,343
ACCOUNTING	0	160	221	170	116	194	$861
WORK COMP INS	0	29	41	31	21	36	$158
SUPPLIES	0	127	176	136	92	154	$686
TELEPHONE	0	127	176	136	92	154	$686
EMPL BENEFITS	0	705	975	751	510	854	$3,795
PAYROLL TAXES	0	388	537	413	280	470	$2,087
TRAVEL	0	61	84	65	44	74	$328
IN SERVICE	0	58	80	61	42	70	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	47	65	50	34	56	$251
OWNERS COMP	0	153	212	163	111	186	$825
INS-PROP,LIAB,WC	0	19	27	21	14	23	$104
DEPRECIATION	0	117	162	125	85	142	$631
RENT	0	323	447	344	234	391	$1,739
MAINTENANCE	0	58	81	62	42	71	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,937	$9,597	$7,387	$5,013	$8,400	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,686	10,633	8,184	5,554	9,307	41,365
EQUIP - CURR	0	3,302	4,567	3,515	2,386	3,998	17,768
EQUIP - FULLY DEP	0	3,548	4,908	3,777	2,564	4,296	19,092
BLDG - PRIOR	0	1,250	1,729	1,331	903	1,513	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	17.92%	26.31%	19.02%	13.50%	23.25%	100.00%
SALARIES-ADMIN	$0	$2,303	$3,381	$2,444	$1,734	$2,987	$12,848
SALARIES-CLERIC	0	1,679	2,465	1,782	1,265	2,179	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	420	616	446	316	545	$2,343
ACCOUNTING	0	154	226	164	116	200	$861
WORK COMP INS	0	28	42	30	21	37	$158
SUPPLIES	0	123	180	130	93	159	$686
TELEPHONE	0	123	181	131	93	160	$686
EMPL BENEFITS	0	680	998	722	512	882	$3,795
PAYROLL TAXES	0	374	549	397	282	485	$2,087
TRAVEL	0	59	86	62	44	76	$328
IN SERVICE	0	56	82	59	42	72	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	45	66	48	34	58	$251
OWNERS COMP	0	148	217	157	111	192	$825
INS-PROP,LIAB,WC	0	19	27	20	14	24	$104
DEPRECIATION	0	113	166	120	85	147	$631
RENT	0	312	458	331	235	404	$1,739
MAINTENANCE	0	56	82	60	42	73	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,692	$9,823	$7,101	$5,039	$8,680	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,414	10,883	7,867	5,583	9,617	41,365
EQUIP - CURR	0	3,185	4,675	3,379	2,398	4,131	17,768
EQUIP - FULLY DEP	0	3,422	5,023	3,631	2,577	4,439	19,092
BLDG - PRIOR	0	1,205	1,769	1,279	908	1,564	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.25%	25.82%	18.98%	13.86%	23.10%	100.00%
SALARIES-ADMIN	$0	$2,344	$3,318	$2,439	$1,780	$2,967	$12,848
SALARIES-CLERIC	0	1,710	2,419	1,778	1,298	2,164	9,370
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	427	605	445	325	541	2,343
ACCOUNTING	0	157	222	163	119	199	861
WORK COMP INS	0	29	41	30	22	37	158
SUPPLIES	0	125	177	130	95	158	686
TELEPHONE	0	125	177	130	95	158	686
EMPL BENEFITS	0	692	980	720	526	876	3,795
PAYROLL TAXES	0	381	539	396	289	482	2,087
TRAVEL	0	60	85	62	45	76	328
IN SERVICE	0	57	80	59	43	72	310
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	46	65	48	35	58	251
OWNERS COMP	0	151	213	157	114	191	825
INS-PROP,LIAB,WC	0	19	27	20	14	24	104
DEPRECIATION	0	115	163	120	87	146	631
RENT	0	317	449	330	241	402	1,739
MAINTENANCE	0	57	81	59	43	72	313
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,812	$9,640	$7,086	$5,174	$8,623	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,548	10,681	7,851	5,732	9,553	41,365
EQUIP - CURR	0	3,242	4,588	3,372	2,462	4,104	17,768
EQUIP - FULLY DEP	0	3,484	4,930	3,624	2,646	4,409	19,092
BLDG - PRIOR	0	1,227	1,736	1,276	932	1,553	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0